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| Q 082 | | | (b)(1) The program must incorporate quality indicator data, including patient care and other relevant data regarding services furnished in the ASC. | | | | (b)(2) The ASC must use the data collected to -  
(i) Monitor the effectiveness and safety of its services, and quality of its care.  
(ii) Identify opportunities that could lead to improvements and changes in its patient care. | 8/9/19 |
| | | | (c)(2) Performance improvement activities must track adverse patient events, examine their causes, implement improvements, and ensure that improvements are sustained over time. | | | | (c)(3) The ASC must implement preventive strategies throughout the facility targeting adverse patient events and ensure that all staff are familiar with these strategies. | |
Continued From page 1

quality assessment and performance improvement (QAPI) program incorporated quality indicator data to monitor the effectiveness and safety of its services and quality of care for 17 of 18 monitors (biomedical engineering, biohazardous waste, housekeeping, contracted laboratory, laundry, maintenance, medical records, nursing, pharmacy, radiology, security, tissue transplant, transcription, discharge, transfer, medication errors and response to patient emergencies).

Findings include:

1. Review of the document titled The Quality Assessment Performance Improvement (QAPI) Plan, approved 12/11/18, together with the "Quality Monitoring Elements 2019" attachment, lacked documentation of quality indicator data to be monitored.

2. Review of 4 quarters of meeting minutes titled "Employee Quality Committee - Quality Reporting", dated 4/11/18, 2/5/19 and 4/29/19; those titled "MedExec Quality Reporting", dated 9/13/18 and 2/5/19; and "Employee Quality Committee - Quality Report to MEC" (Medical Executive Committee), dated 4/30/19; lacked documentation of inclusion of quality indicator data collected or reviewed for monitoring and analysis of biomedical engineering, biohazardous waste, housekeeping, contracted laboratory, laundry, maintenance, medical records, nursing, pharmacy, radiology, security, tissue transplant, transcription, discharge, transfer, medication errors and/or response to patient emergencies.

3. On 6/25/19, between approximately 12:30 p.m. and 1:30 p.m. A1, Office Manager, verified
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<td>Q 082</td>
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<td>the QAPI Plan did not provide for data collection methods and that no detail had been established for incorporation of data collection for monitoring of biomedical engineering, biohazard waste, housekeeping, laundry, maintenance, medical record review, nursing, pharmacy, security, discharge, transfer, infection control, medication errors and response to patient emergencies.</td>
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<tr>
<td>Q 104</td>
<td>SAFETY FROM FIRE</td>
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<td>(b) Standard: Safety from fire. (1) Except as otherwise provided in this section, the ASC must</td>
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**Q 100 ENVIRONMENT**

CFR(s): 416.44

The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients.

This CONDITION is not met as evidenced by:

Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm system was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code (see tag K345), and failed to provide quarterly fire drill documentation during 1 of 4 quarters (see tag K712).

The cumulative effect of these systemic problems resulted in the facility's inability to ensure that all locations from which it provides services are constructed, arranged and maintained to ensure the provision of quality health care in a safe environment.

**Q 104 SAFETY FROM FIRE**

CFR(s): 416.44(b)(1)-(3)

(b) Standard: Safety from fire. (1) Except as otherwise provided in this section, the ASC must
Q 104 Continued From page 3
meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served, and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4).

(2) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon an ASC, but only if the waiver will not adversely affect the health and safety of the patients.

(3) The provisions of the Life Safety Code do not apply in a State if CMS finds that a fire and safety code imposed by State law adequately protects patients in an ASC. This STANDARD is not met as evidenced by:

1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm system was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the Table 14.4.5 Testing Frequencies. NFPA 72, 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. NFPA 72, 14.4.5.3.5 states smoke detectors or smoke alarms found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This
Q 104 Continued From page 4

deficient practice could affect all occupants.

Findings include:

Based on record review on 07/16/19 between 9:45 a.m. and 1:15 p.m. with the Administrator and PRN/X-ray Tech present, no smoke detector sensitivity test was available for review. Based on interview at the time of record review, the Administrator confirmed no documentation for smoke detector sensitivity was available for review.

2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually:
   a. Control unit trouble signals
   b. Remote annunciators
   c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.)
   d. Notification appliances
   e. Magnetic hold-open devices

This deficient practice could affect all occupants in the facility.

Findings include:

Based on record review on 07/16/19 between 9:45 a.m. and 1:15 p.m. with the Administrator and PRN/X-ray Tech present, no documentation...
### Summary of Deficiencies

**Q 104 Continued From page 5**

Could be provided regarding a visual semi-annual fire alarm system inspection. Based on interview at the time of record review, the Administrator said that visual inspections of the fire-alarm system's devices were not performed on a semi-annual basis.

3. Based on record review and interview, the facility failed to provide quarterly fire drill documentation during 1 of 4 quarters. This deficient practice could affect all occupants in the facility.

Findings include:

Based on review of the facility's fire drill reports on 07/16/19 at 11:30 a.m. with the Administrator and PRN/X-ray Tech present, the facility lacked fire drill documentation for the fourth quarter (October, November, and December) of 2018. Based on interview at the time of record review, the Administrator said there was no other documentation available to show a fire drill was performed during the fourth quarter of 2018.

4. Based on record review and interview, the facility failed to ensure the fire alarm system was activated during 3 of 3 fire drills performed during the past 12 months. This deficient practice could affect all occupants in the facility.

Findings include:

Based on record review on 07/16/19 at 11:30 a.m. with the Administrator and PRN/X-ray Tech present, documentation for fire drills performed on 09/2018 (no day), 01/25/19, and 04/27/19 had a question for each drill that said "Alarm Activated" with a "yes" or "no" answer. The
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<td>Q 121</td>
<td>MEMBERSHIP AND CLINICAL PRIVILEGES</td>
<td>CFR(s): 416.45(a)</td>
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Members of the medical staff must be legally and professionally qualified for the positions to which they are appointed and for the performance of privileges granted. The ASC grants privileges in accordance with recommendations from qualified medical personnel.

This STANDARD is not met as evidenced by:

Based on document review and interview, the Medical Staff (MS) failed to ensure that allied health practitioner privileges were granted in accordance with recommendations from qualified medical personnel based on their experience and competence for 5 of 5 allied health members (AH1, AH2, AH3, AH4 and AH5).

Findings include:

1. Review of the Medical Staff Bylaws, approved 2/13/17, indicated the following:
   
   Article III - Membership
   Section I. Divisions and Qualifications.
   D. AHP (Allied Health Professional)
   Staff: Each member of the AHP Staff must be qualified by academic and clinical training to function in a medical support role...

   E. All members of the Staff and affiliated AHP's shall be competent in their respective fields, be worthy in character and in matters of professional ethic, and have
Q 121 Continued From page 7

qualifications acceptable to the Board of Managers.

Section IV. Procedures for Appointment.  
C. The Credentials and Peer Review Committee shall investigate the character, professional competence, ethical standing, and other qualifications of the applicant, having proper consultations and conducting such personal interviews as may be necessary.

Article IV - Categories of Staff and AHPs  
Section V. AHPs  
B. Qualifications. Only AHPs of a profession approved by the Board of managers...who:

1. document their experience, background, training, professional liability insurance, ability, physical and mental health status with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency that they are qualified to provide...

2. are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions as applicable...to provide specified services...

2. Review of credential files for AHP members AH1, AH2, AH3, AH4 and AH5, lacked documentation of the practitioners experience and competence to perform tasks/procedures for which they were granted privileges.

3. On 6/25/19 between approximately 10:00 a.m. and 11:00 a.m., A3, Credentialing Manager, verified that the center did not have documentation of AHPs experience and competency.
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| Q 241 | Continued From page 8 | Q 241 | SANITARY ENVIRONMENT

CFR(s): 416.51(a)

The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice.

This STANDARD is not met as evidenced by:

Based on document review, observation and interview, the facility failed to provide a safe environment in 5 instances during survey.

1. Facility Policy #10.38, Immediate Use Steam Sterilization (I USS), last reapproved 12/11/2018, indicated:

   A. Immediate Use Steam Sterilization shall not be used as a substitute for insufficient inventory.

2. On 6/24/2019 at 1230 hours, staff member #NO2, Infection Control Nurse, indicated in interview that we do IUSS sometimes when a physician does one case right after another on busy days, to have instruments ready for next cases.

3. Facility Policy #10.12, Operating Room Attire, last reapproved 12/11/2018, indicated: All head and facial hair, including sideburns shall be covered in the restricted areas of the surgical suite.

4. On 6/25/2019 at approximately 1200 hours, during observation of a surgical case, it was noted that 3 nursing staff (staff #NO3, NO4 and NO5) and 1 physician (#P2) failed to have their hair completely covered by surgical caps, on
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<td></td>
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<td>Continued From page 9 sides and in back of head. Staff #NO5 also had hair uncovered on forehead.</td>
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